DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
DOH1104 (C08/92)

STATE OF WISCONSIN

Active Treatment for Mentally Ill Nursing Facility Residents
Roster Claim Form

Facility Name and City _____ Page ___ of ___

Facility Medical Assistance Number _____ Month _____ Year ___

A Resident Name	B Resident's Medical Assistance #	C Date of Admission	D Date of Level II Screen	E Date of Active Treatment Determination *	F Total In-House Days	G Total Supplement Requested **
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
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17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.					Page Total	

* Date on the letter sent to the facility from the county or the State Office of Mental Health indicating the need for active treatment.

** Number of in-house days X $9.00

CERTIFICATION:
This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from state funds, and that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable state laws.

Name and Title _____ Signature _____ Date _____ Phone number for questions _____